



# Myanmar International School

No. 20, Pyin Nya Waddy Street, Yankin Township, Yangon

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## Student Enrolment Form

Date: \_\_\_\_\_

### Student information

Name: \_\_\_\_\_ Preferred Name (if any): \_\_\_\_\_

First Middle Last

Male  Female Date of Birth: \_\_\_\_\_ Current Age: \_\_\_ Years \_\_\_ Months Place of Birth: \_\_\_\_\_  
(DD/MM/YY)

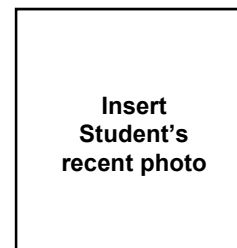
Nationality: \_\_\_\_\_ Religion: \_\_\_\_\_ Passport / NRC NO: \_\_\_\_\_

Last Year/Grade Level Completed: \_\_\_\_\_ Year Level Applied for: \_\_\_\_\_

First Language: \_\_\_\_\_ Please circle: Beginner/ Intermediate/ Advanced

Second Language: \_\_\_\_\_ Please circle :Beginner/ Intermediate/ Advanced

Other: \_\_\_\_\_ Please circle: Beginner/ Intermediate/ Advanced



Brother / sister currently studying at MIS: \_\_\_\_\_ Year: \_\_\_\_\_  
First Middle Last

### Schools attended:

Name of school	Year / grade	Attended from	To	Language of instruction

**Placement test:**

Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
Level: \_\_\_\_\_  
English Results: \_\_\_\_\_  
  
Maths Results: \_\_\_\_\_

-----Official Use Only-----

Meets MIS Entry Requirement for Year Level: \_\_\_\_\_

Academic Year: \_\_\_\_\_

Class/teacher Assigned: \_\_\_\_\_

Principal's comment: \_\_\_\_\_

Starting Date: \_\_\_\_\_

Enrolment Form Completed		Photos	
Previous School Records Submitted		Birth Certificate/Passport copy	
MIS Information Medical Form Completed		Medical Records Submitted	
Registration Fee Paid		School Fee Paid	
Signed Agreement Form Submitted			

### Parent/Guardian's Information

Father's Name:	Mother's Name:
Nationality:	Nationality:
Telephone:	Telephone:
Email:	Email:
Passport Number:	Passport Number:
Company/Business:	Company/Business:
Home Address:	
Position/Title:	Position/Title:
Children are living with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian	
Insert Father's recent photo	Insert Mother's recent photo
<b>If Guardian:</b> Name:	Relation to child:
Nationality:	Telephone:
Email:	Business:
Home Address:	Insert Guardian's recent photo

### Authorized person's details to pick up and drop your child from/to school:

Name:	Gender:
Job:	Telephone:
Insert Authorized person's recent photo	

Please tick the box below which lets us know how you heard about MIS:

- Word of mouth                       Website                       Facebook                       Other

Parent's signature: \_\_\_\_\_ Name: \_\_\_\_\_

Student's Full Name: \_\_\_\_\_ Class: \_\_\_\_\_ Date: \_\_\_\_\_

## MYANMAR INTERNATIONAL SCHOOL: MEDICAL INFORMATION

Student's Full Name \_\_\_\_\_ Class \_\_\_\_\_

Does your child suffer from any of the following conditions?

(Tick those which apply)

Asthma		Diabetes	
Chest problems		Fainting	
Epilepsy		Migraine	
Heart trouble			

If you have ticked any of the above, please provide details

Does your child suffer from any other condition requiring medication?

YES / NO

If YES, please provide details:

Does your child have any of the following conditions, Dyslexia, ADHD, Dyspraxia, Dyscalculia, Dysgraphia

If YES, please provide details:

Is your child allergic or sensitive to any medication, insect bites, stings or food?

YES / NO

If YES, please provide details:

Is your child taking any form of medication on a regular basis?

YES / NO

If YES, please provide details:

To the best of your knowledge, has your child been in contact with any contagious or infectious diseases, or suffered any recent condition that may become infectious or contagious.

YES / NO

If YES, please provide details:

Does your child need to wear glasses or hearing aids?

YES / NO

If YES, please provide details:

When did your child last have his/her eyes tested? \_\_\_\_\_

(If longer than 12 months, please have them tested by an optician.)

### Emergency treatment

The School will contact you as soon as possible should an emergency occur but please sign to confirm that you give permission for the school to administer any urgent medical treatment that is required and to take the child to hospital.

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_